Status:	As Filed (Provider Version) --	X	Desk Reviewed --	
	Revised Desk Reviewed --		Field Audited --	

DEPARTMENT OF HUMAN RESOURCES - DIVISION OF MEDICAL ASSISTANCE

2007 FEDERALLY QUALIFIED HEALTH CENTER \ RURAL HEALTH CLINIC

1. Name and Address					
Name of Facility:					
Street or P.O. Box:					
City:		State:		Zip:	
County:		Telephone No:			
2. Cost Reporting Period	From:		To:		

3. Medicaid Provider No.:	NPI Provider No.:	Medicaid Provider No.:	NPI Provider No.:

4. Type of Control				
	a. Voluntary Nonprofit		b. Proprietary	
	1. Corporation		3. Individual	
	2. Other (Specify)		4. Corporation	
			5. Partnership	
			6. Other (Specify)	
	c. Government			
	7. Federal		10. State	
	8. City/County		11. City	
	9. County		12. Other (Specify)	

5. If we have questions regarding the cost report, who should we contact?				6. If the Notice of Program Reimbursement Settlement should be mailed to other than the facility, please list the name and address.			
Name:							
Address:				Name:			
City:				Address:			
State:		Zip:		City:			
Contact Name:				State:		Zip:	
Telephone:							
E-Mail:							

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND STATE LAW.

CERTIFICATION STATEMENT

I HEREBY CERTIFY that I have read the above statement and examined the accompanying schedules prepared by _____ for the cost report period beginning _____

(Name of Facility)

and ending _____ and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the facility in accordance with applicable instructions, except as noted.

Signature _____

(Officer or Administrator)

Title _____

Date _____

PROVIDER NO. NPI NO.	COST OF MEDICAID CORE SERVICES 2007 COST REPORT	Reporting Period From: To:

	2006 (1)	2007 (2)	TOTAL (3)
1. Rate for Medicare Covered Visits (W/S C, Part I, Line 9).			
2. Medicaid Covered Visits for Core Services (From Provider Records) Excluding Mental Health Services			
3. Medicaid Cost for Core Services (Line 1 x 2)			
4. Medicaid Covered Visits for Mental Health Services (From Provider Records)			
5. Medicaid Covered Cost for Mental Health Services (From Provider Records) (Line 1 x 4)			
6. Limit Adjustment (Lines 5 x 62.5%)			
7. Total Medicaid Cost for Core Services (Line 3 + 6)			

PROVIDER NO. NPI NO.	COST OF OTHER AMBULATORY SERVICES 2007 COST REPORT	Reporting Period From: To:

1. Cost Other Than RHC/FQHC Services - (Sum of Lines 1a - 1j) (Figures are from Medicare W/S A, Column 7, Lines 51 - 56)		
a. Pharmacy		
b. Dental		
c. Healthcheck Services (formerly EPSDT)		
d. Maternity Care Coordination		
e. Child Services Coordination		
f. Radiology Services (on-site)		
g. Norplant Services		
h. Physician Hospital Services		
i. Healthcheck Coordinator	**(Note 1)**	
j. Other (Specify)		
*2. Cost of All Services - excluding overhead (W/S B, Line 12)		
3. Percentage of Other FQHC Services (Line 1 / 2)		
4. Total Overhead (W/S B, Line 14)		
5. Overhead Cost Applicable to RHC/FQHC Services (Line 3 x 4)		

*WIC Program
Patient Transportation
Outstationed Eligibility Workers

Note 1: No entry required on this schedule. Healthcheck Coordinator total cost should be reported on Schedule DMA-4, Line 1i, Column 4.

PROVIDER NO. NPI NO.	ALLOCATION OF OVERHEAD COST 2007 COST REPORT	Reporting Period From: To:

(1)	Cost Per DMA-2 (2)	Overhead Cost (Line 4, Col 2 x Lines 1a-1j Col 2) (3)	Total Cost (Col 2 + 3) (4)	Total Encounters/ Units of Service (From Provider Records) (5)	Cost Per Encounter (Col 4 / 5) (6)
1. RHC/FQHC Ambulatory Services					
a. Pharmacy *					
b. Dental **					
c. Healthcheck Services (formerly EPSDT)					
d. Maternity Care Coordination					
e. Child Services Coordination					
f. Radiology Services (on-site)					
g. Norplant Services					
h. Physician Hospital Services					
i. Healthcheck Coordinator.	**(Note 1)**	**(Note 1)**	**(Note 1)**	**(Note 1)**	**(Note 1)**
j. Other (Specify)					
2. Total Cost (Lines 1a-1j)					
3. Overhead Cost (DMA-2, Line 5)					
4. Unit Cost Multiplier (3 / 2)		Agrees with Line 3, Col 2			

* Number of prescriptions

** Encounter

Note 1: No entry required on this schedule. Healthcheck Coordinator total cost should be reported on Schedule DMA-4, Line 1i, Column 4.

PROVIDER NO. NPI NO.	DETERMINATION OF MEDICAID REIMBURSEMENT 2007 COST REPORT	Reporting Period From: To:

(1)	Cost Per Encounter DMA-3 (2)	Medicaid Encounters (From Provider Records) (3)	Medicaid Cost (Col 2 x 3) (4)	
1. RHC/FQHC Services				
a. Pharmacy				
b. Dental				
c. Healthcheck Services (Formerly EPSDT)				
d. Maternity Care Coordination				
e. Child Services Coordination				
f. Radiology Services (on-site)				
g. Norplant Services				
h. Physician Hospital Services				
i. Healthcheck Coordinator.	**(Note 1)**	**(Note 1)**		
j. Other (Specify)				
2. Subtotal				
3. Less: Physician Hospital Services and Healthcheck Coordinator.				
4. Total Ambulatory Services (Line 2 - 3)				
5. Medicaid Core Service Cost				(DMA-1, Line 7)
6. Medicaid Cost of Pneumococcal and Influenza Vaccine				(DMA-7, Line 4)
7. Total Reimbursable Cost (Line 4 + 5 + 6)				
8. Amount Received/Receivable from Medicaid (From Provider Records)				(DMA-5, Line 6)
9. Amount Due Provider <Program> Exclusive of Bad Debts (Line 7 - 8)				
10. Reimbursable Bad Debts				(DMA-6, Line 5)
11. Total Amount Due Provider <Program> (Line 9 + 10)				

Note 1: No entry required in these blocks. Healthcheck Coordinator total cost should be reported on Schedule DMA-4, Line 1i, Column 4.

PROVIDER NO. NPI NO.	SUMMARY OF MEDICAID PAYMENTS 2007 COST REPORT	Reporting Period From: To:

(1)	Amount * (From Provider Records) (2)	Provider Number/s (3)	
1. RHC/FQHC Payments			
*a. Pharmacy			
*b. Dental			
c. Healthcheck Services (formerly EPSDT)			
d. Maternity Care Coordination			
e. Child Services Coordination			
*f. Radiology Services (on-site)			
g. Norplant Services			
h. Physician Hospital Services			
i. Healthcheck Coordinator			
j. Other (Specify)			
2. Core Services			
3. Third Party Liability			
4. Subtotal			
5. Less: Physician Hospital Services and Healthcheck Coordinator			
6. Total Medicaid Payments (Line 4 - 5)			(DMA-4, Line 8)

*** Note:** Co-pay not applicable to Core Services.
Co-pay is applicable to Ambulatory Services.
Carolina Access payments are not to be included.
Medicaid crossover payments are not to be included.

Comments:

PROVIDER NO. NPI NO.	BAD DEBTS 2007 COST REPORT	Reporting Period From: To:

(1)	Amount (2)	
1. Co-Payment Billed to Medicaid Patients (From Provider Records)		
2. Co-Payment Amounts Received From Medicaid Patients (From Provider Records)		
3. Medicaid Bad Debts (Line 1 - 2)		
4. Less Medicaid Bad Debt Recoveries (From Provider Records)		
5. Net Bad Debts (Line 3 - 4)		(DMA-4, Line 10)

PROVIDER NO. NPI NO.	COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES 2007 COST REPORT	Reporting Period From: To:

(1)	Pneumococcal (2)	Influenza (3)
1. Cost Per Pneumococcal and Influenza Vaccine Injection (Supplemental W/S B-1, Line 12)		
2. Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicaid Beneficiaries (From Provider Records)		
3. Medicaid Cost of Pneumococcal and Influenza Vaccine Injections and their Administration (Line 1 x 2)		
4. Total Medicaid Cost of Pneumococcal and Influenza Vaccine Injections and their Administration (Sum of Line 3, Columns 2 and 3) Transfer to Schedule DMA-4, Line 6		

PROVIDER NO. NPI NO.	PPS RECONCILIATION SCHEDULE 2007 COST REPORT	Reporting Period From: To:

	Encounters		
a. Core Services			
b. Dental			
c. EPSDT			
d. Norplant			
e. Home Health			
1. Total Encounters (Sum of Lines a-e)			
2. PPS Rate			
3. Total Prospective Payments with PPS Rate (Line 1 x 2)			
4. Total Reimbursable Cost from DMA-4			(DMA-4, Line 7 + DMA-4, Line 10)
5. Greater of PPS Payment or Reimbursable Cost			**Cost Settlement**
6. Amount Received from Medicaid			(DMA-5, Line 6)
7. Gross Amount Due Provider <Program>*			(Line 5 - Line 6)

***** Amount due Program must be forwarded with As Filed Cost Report.

Settlement is in accordance with North Carolina Medicaid State Plan Attachment 4.19-B Section 2.